PLAN DESIGN & BENEFITS
WA Group Business 51-100 Employees

| PLAN FEATURES | NETWORK CARE | OUT-OF-NETWORK CARE |
|---|---|---|
| **Primary Care Physician Selection** | Not applicable | Not applicable |
| **Deductible** (per calendar year) | $5,000 Individual<br>$10,000 Family | $10,000 Individual<br>$30,000 Family |
| Unless otherwise indicated, the deductible must be met before benefits can be paid. | | |
| All covered expenses accumulate separately toward the network and out-of-network Deductible. | | |
| As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible. | | |
| No one family member may contribute more than the individual deductible amount to the family deductible. Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the year. | | |
| **Member Coinsurance**<br>(applies to all expenses unless otherwise stated) | 0% | 50% |
| **Out-of-Pocket (OOP) Maximum**<br>(per calendar year, includes deductible) | $7,500 Individual<br>$15,000 Family | $25,000 Individual<br>$75,000 Family |
| All covered expenses accumulate separately toward the network and out-of-network Out of Pocket Limit. | | |
| Pharmacy expenses apply towards the Out-of-Pocket Maximum.<br>Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the out-of-pocket maximum. | | |
| No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, all family members will be considered as having met their out-of-pocket maximum for the remainder of the year. | | |
| **Payment for Out-of-Network Care*** | Not applicable | Professional: 105% of Medicare<br>Facility: 140% of Medicare |
| **Precertification Requirements** | | |
| Some out-of-network services need approval by us in advance (precertification). Without this approval, a benefit reduction of $400 per occurrence applies separately to each type of covered service. Refer to your plan documents for a full list of services that need this approval. | | |
| **Referral Requirement** | Not applicable | Not applicable |
| **PHYSICIAN SERVICES** | **NETWORK CARE** | **OUT-OF-NETWORK CARE** |
| **Office Visits to Non-Specialist** | $35 copay deductible waived | 50% after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury. | | |
| **Telemedicine Consultations with Non-Specialist** | $35 copay deductible waived | 50% after deductible |
| **Virtual Primary Care Telemedicine Provider Consultations**<br>Includes basic medical and preventive health care services for persons 18 years of age or older. Telemedicine preventive screening and counseling services are subject to the preventive care benefit. | Covered in full | Not Covered |
| **Non-Specialist Telemedicine Provider Consultations** | Covered in full | Not Covered |
| **Specialist Office Visits** | $75 copay deductible waived | 50% after deductible |
| **Telemedicine Consultations with Specialist** | $75 copay deductible waived | 50% after deductible |
| **Specialist Telemedicine Provider Consultations** | Covered in full | Not Covered |
| **Non-Specialist and Specialist Surgical Services** | Covered in full after deductible | 50% after deductible |
| **Walk-in Clinics** | $35 copay deductible waived | 50% after deductible |
| Walk-in clinics are freestanding health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be walk-in clinics. | | |
| **Maternity - Delivery and Post-Partum Care** | Covered in full after deductible | 50% after deductible |

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| **Allergy Testing** | Cost-sharing is based on type of service and where it is received. | 50% after deductible |
| **Allergy Injections** | Covered in full after deductible | 50% after deductible |
| PREVENTIVE CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| Preventive care services are covered in accordance with Health Care Reform. | | |
| **Routine Adult Physical Exams and Immunizations**<br>Coverage is limited to 1 exam every 12 months. | Covered in full | 50% after deductible |
| **Well Child Exams and Immunizations**<br>Coverage is limited 7 exams in the first 12 months of life; 3 exams in the second 12 months of life; 3 exams in the third 12 months of life; 1 exam every 12 months thereafter to age 22. | Covered in full | 50% after deductible |
| **Routine Gynecological Exams**<br>Includes routine tests and related lab fees.<br>Coverage is limited to 1 exam every 12 months. | Covered in full | 50% after deductible |
| **Routine Mammograms** | Covered in full | 50% after deductible |
| **Women's Health**<br>Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | Covered in full | 50% after deductible |
| **Prenatal Maternity** | Covered in full | 50% after deductible |
| **Routine Digital Rectal Exam / Prostate-Specific Antigen Test**<br>Recommended: For covered males age 40 and over. | Covered in full | 50% after deductible |
| **Colorectal Cancer Screening**<br>Recommended: For all members age 45 and over. | Covered in full | 50% after deductible |
| **Routine Eye and Hearing Screenings** | Paid as part of routine physical exam. | Paid as part of routine physical exam. |
| HEARING SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Hearing Exam** (by Specialist) | Not covered | Not covered |
| **Hearing Aid**<br>Coverage is limited to 1 per ear every 36 months. | Covered in full | 50% after deductible |
| VISION SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Adult Routine Eye Exams (Refraction)**<br>Coverage is limited to 1 exam every 12 months. | Covered in full | 50% after deductible |
| **Pediatric Routine Eye Exams (Refraction)**<br>Coverage is limited to 1 exam every 12 months. | Covered in full | 50% after deductible |
| **Adult Vision Hardware** | Not Covered | Not Covered |
| **Pediatric Vision Hardware** | Not Covered | Not Covered |
| DIAGNOSTIC PROCEDURES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Diagnostic Laboratory** | Covered in full after deductible | 50% after deductible |
| **Diagnostic X-ray (except for Complex Imaging Services)** | Covered in full after deductible | 50% after deductible |

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| **Diagnostic X-ray for Complex Imaging Services** (Including, but not limited to, MRI, MRA, PET and CT Scans) | Covered in full after deductible | 50% after deductible |
| EMERGENCY MEDICAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Urgent Care Provider** | $75 copay deductible waived | 50% after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not covered | Not covered |
| **Emergency Room** Copay waived if admitted. | $300 copayment after deductible | Paid as in-network |
| **Non-Emergency Care in an Emergency Room** | Not covered | Not covered |
| **Emergency Use of Ambulance** | Covered in full after deductible | Paid as in-network |
| **Non-Emergency Use of Ambulance** | Covered in full after deductible | Paid as in-network |
| HOSPITAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Coverage** Including maternity (delivery and postpartum care). The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | Covered in full after deductible | 50% after deductible |
| **Outpatient Surgery** Provided in an outpatient hospital department or freestanding surgical facility. | Covered in full after deductible | 50% after deductible |
| **Colonoscopy** (non-preventive) | Cost-sharing is based on type of service and where it is received. | Cost-sharing is based on type of service and where it is received. |
| **Transplants** Coverage is limited to IOE facilities only. | Covered in full after deductible | Not covered |
| BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH and SUBSTANCE RELATED DISORDERS) | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Services (including inpatient residential treatment facility)** The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | Covered in full after deductible | 50% after deductible |
| **Outpatient Office Visits** The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | Covered in full | 50% after deductible |
| **Physician or Behavioral Health Provider Telemedicine Consultations** | Covered in full | 50% after deductible |
| **Telemedicine Provider Consultations** | Covered in full | Not Covered |
| **Other Outpatient Services** (Includes partial hospitalization treatment, intensive outpatient program.) | Covered in full after deductible | 50% after deductible |
| THERAPY SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Outpatient Chiropractic/Spinal Manipulation Therapy** Coverage is limited to 20 visits per calendar year. | $75 copayment after deductible | 50% after deductible |
| **Outpatient Short-Term Rehabilitation - Physical Therapy** Coverage is limited to 30 visits per calendar year PT/OT/ST combined. Limits do not apply to neurodevelopmental therapies. | $75 copayment after deductible | 50% after deductible |

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| **Outpatient Short-Term Rehabilitation - Occupational Therapy**<br>Coverage is limited to 30 visits per calendar year PT/OT/ST combined. Limits do not apply to neurodevelopmental therapies. | $75 copayment after deductible | 50% after deductible |
| **Outpatient Short-Term Rehabilitation - Speech Therapy**<br>Coverage is limited to 30 visits per calendar year PT/OT/ST combined. Limits do not apply to neurodevelopmental therapies. | $75 copayment after deductible | 50% after deductible |
| **Habilitative Physical, Occupational and Speech Therapy** | Covered in full after deductible | 50% after deductible |
| **Autism Physical, Occupational and Speech Therapy** | Covered in full after deductible | 50% after deductible |
| **Autism Behavioral Therapy** | Covered in full | 50% after deductible |
| **Autism Applied Behavior Analysis** | Covered in full after deductible | 50% after deductible |
| OTHER SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Skilled Nursing Facility**<br>Coverage is limited to 60 days per calendar year.<br><br>The member cost sharing applies to all covered benefits incurring during a member's inpatient stay. | Covered in full after deductible | 50% after deductible |
| **Home Health Care**<br>Coverage is limited to 60 visits per calendar year.<br>1 visit equals a period of 4 hours or less. | Covered in full after deductible | 50% after deductible |
| **Infusion Therapy**<br>Provided in the home or physician's office. | Covered in full after deductible | 50% after deductible |
| **Infusion Therapy**<br>Provided in the outpatient hospital department of freestanding facility. | Covered in full after deductible | 50% after deductible |
| **Gene-Based, Cellular and Other Innovative Therapies (GCIT)**<br>Coverage is limited to GCIT designated facilities only. | Cost-sharing is based on type of service and where it is received. | Not covered |
| **Inpatient Hospice Care**<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | Covered in full after deductible | 50% after deductible |
| **Outpatient Hospice Care**<br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | Covered in full after deductible | 50% after deductible |
| **Private Duty Nursing -** Outpatient | Not covered | Not covered |
| **Acupuncture**<br>Coverage is limited to 10 visits per calendar year. | $35 copay deductible waived | 50% after deductible |
| **Durable Medical Equipment** | Covered in full after deductible | 50% after deductible |
| **Prosthetics** | Covered in full after deductible | 50% after deductible |
| **Diabetic Supplies not obtainable at a pharmacy** | Covered same as any other medical expense. | Covered same as any other medical expense. |
| **Mouth, Jaws and Teeth**<br>Coverage for medical in nature oral surgery only. No coverage for dental in nature oral surgery or for removal of impacted teeth. | Cost-sharing is based on type of service and where it is received. | 50% after deductible |
| **Bariatric Surgery** | Not covered | Not covered |
| FAMILY PLANNING | NETWORK CARE | OUT-OF-NETWORK CARE |

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| **Basic Infertility**<br>Coverage is limited to the diagnosis and treatment of the underlying medical condition, including artificial insemination. | Cost-sharing is based on type of service and where it is received. | Cost-sharing is based on type of service and where it is received. |
| **Advanced Reproductive Technology (ART)**<br>In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery and ovulation induction | Not covered | Not covered |
| **Fertility preservation** | Not covered | Not covered |
| **Vasectomy** | Covered in full | 50% after deductible |
| **Tubal Ligation** | Covered in full | 50% after deductible |
| PHARMACY DEDUCTIBLE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Prescription drug calendar year deductible** | Not Applicable under both the network care and out-of-network columns. | Not Applicable under both the network care and out-of-network columns. |
| PHARMACY - PRESCRIPTION DRUG BENEFITS | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Generic Drugs** | | |
| **Retail** | Generic - T1A: $3 copayment<br>Generic - T1: $10 copayment | 50% |
| **Mail Order** | Generic - T1A: $6 copayment<br>Generic - T1: $20 copayment | Not covered |
| **Preferred Brand Drugs** | | |
| **Retail** | $50 copayment | 50% |
| **Mail Order** | $100 copayment | Not covered |
| **Non-Preferred Generic and Brand Drugs** | | |
| **Retail** | $80 copayment | 50% |
| **Mail Order** | $160 copayment | Not covered |
| **Specialty Drugs** | | |
| **Preferred Specialty** | $250 copayment | Not covered |
| **Non-Preferred Specialty** | $250 copayment | Not covered |
| **Pharmacy Day Supply and Requirements** | | |
| **Retail**<br>Up to 90 days supply. 30 day supply= retail cost share; 31-90 day supply= mail order cost share from the Aetna National Pharmacy Network | | |
| **Mail Order**<br>31-90 day supply from CVS Caremark Mail Service Pharmacy™ | | |

**Specialty-** Up to a 30 day supply.

**Choose Generics with Dispense as Written (DAW) override -** Choose Generic with DAW Override - Penalty applies to integrated MOOP

**Precertification -** Included. See formulary for details.

**Step Therapy -** Included. See formulary for details.

**Pharmacy Plan includes:**

Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

Contraceptives may be dispensed for up to a 12 month supply at one time.

Preventive and seasonal vaccinations covered 100% in-network.

Cost share will not exceed $25 per fill per 30 day supply for formulary insulin, $35 per fill per 30 day supply for non-formulary insulin, $35 per fill per 30 day supply for asthma inhaler; and $17 per device for epinephrine.

**Performance Enhancing Drugs -** Coverage is excluded for lifestyle/performance drugs.

Not all drugs are covered. It is important to look at the Drug List (Advanced Control Plan - Aetna Formulary) to understand which drugs are covered.

***How out-of-network care is reimbursed:**

We cover the cost of services based on whether doctors are “in network” or “out of network.” We want to help members understand how much Aetna pays for their out-of-network care. At the same time, we want to make it clear how much more members will need to pay for this "out-of-network" care.

Members may choose a provider (doctor or hospital) in our network. Members may choose to visit an out-of-network provider. If a member chooses a doctor who is out of network, their Aetna health plan may pay some of that doctor's bill. Most of the time, members will pay a lot more money out of their own pocket if they choose to use an out-of-network doctor or hospital.

When members choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

The members' doctor sets his or her own rate to charge members. These rates may be higher -- sometimes much higher -- than what the members' Aetna plan "recognizes." Members' doctors may bill them for the dollar amount that their plan doesn't "recognize." Members must also pay any copayments, coinsurance and deductibles under their plan. No dollar amount above the "recognized charge" counts toward their deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit **Aetna.com**. Type "how Aetna pays" in the search box.

Members can avoid these extra costs by getting their care from Aetna's network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. Members can sign on to the Aetna member site.

This applies when members choose to get care out of network. When members have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if the member got care in network. Members pay cost sharing and deductibles for their in-network level of benefits. Members should contact Aetna if their health care provider asks them to pay more. Members are not responsible for any outstanding balance billed by their providers for emergency services beyond their cost sharing and deductibles.

**What's Not Covered**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors;Cosmetic surgery; Custodial care; Dental services; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;
Nonmedically necessary services or supplies; Orthotics, except diabetic orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

Medications on the Aetna Drug Guide, precertification, step-therapy and quantity limits lists are subject to change.

Aetna, CVS Pharmacy® and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are part of the CVS Health® family of companies.CVS Caremark® Mail Service Pharmacy and Aetna are part of the CVS Health® family of companies.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

While this information is believed to be accurate as of the print date, it is subject to change. For more information about Aetna plans, refer to **Aetna.com**.

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